STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure survey. This visit included the investigation of Complaint IN00109927. Complaint IN00109927: Substantiated. State Residential deficiencies related to the allegations are cited at R52, R53, R214, and R217. Survey dates: June 18, 19, 20, and 21, 2012 Facility number: 012263 Provider number: 012263 AIM number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Heather Lay, R.N. Melanie Strycker, R.N. Census bed type: Residential--108 Total--108 Census payor type: Other--108 Total--108 Sample: 10 These State Residential findings are cited	R0000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	in accordance with 410 IAC 16.2. Quality review completed 6/28/12 Cathy Emswiller RN			

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R0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify a resident's physician and legal representative for a significant change in the resident's physical status. The deficient practice affected 1 of 1 resident reviewed for notification of change in condition in a sample of 10 residents reviewed. [Resident #C] Findings include: On 6/18/12 at 10:30 A.M., tour of the facility's locked unit [dementia unit] was initiated with L.P.N. #1. At that time, Resident #C was identified as non-interviewable with a history of falls requiring staff assistance with all activities of daily living. On 6/20/12 at 6:05 A.M., Resident #C's record was reviewed. Diagnoses included, but were not limited to, vascular	R0036	1. Resident's physician and legal representative will be notified in the event of a significant decline in resident's physical, mental, or psychosocial status or a need to alter treatment significantly. 2. A random audit of 11 out of 108 charts was completed to review change of condition status updates. Notification of resident's physician and the resident's legal representative was noted. 3. An in-service (See attachment A) was performed for our nursing staff to review change of condition status and proper notification of resident's physician and the resident's legal representative. 4. Monthly monitoring of our change of condition procedure will be done by our Director of Nursing. Director of Nursing will report findings during the QA meetings quarterly.	07/09/2012

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	dementia, hypertension, and history of cerebral vascular accident [stroke] with left-sided hemiplegia. Resident #C was admitted to the facility assisted living on 1/16/12 and to the facility's locked [dementia] unit on 2/15/12. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 12/21/11, no time, included, but was not limited to, "Fall Risk: Services Provided: Uses wheelchair primary mode of transportation able to ambulate with walker... Independent with ambulation... Requires escort to most daily meals, activities and outings... High [fall risk]... Transferring: [Resident #C] Independent with transfers... Requires occasional assistance and or cueing [with transfers}..." A "Nursing Progress Notes" dated 1/27/12 at 9:45 P.M., included, but was not limited to, "Resident requires assist of 2 to bathroom and returned to bed... Resident unable to stand or assist with transfers... increased confusion... Action Taken: Certified Nursing Assistant [C.N.A.] and Qualified Medication Aide [Q.M.A.] attempted unsuccessfully to reorient resident [Resident #C]... C.N.A.			

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	and Q.M.A. provided total assistance of 2 to toilet resident... Resident did not stand during transfers... Outcome: Resident [#C] remained angered and with increased confusion... no PRN's [as needed medications] available for increased agitation..." No documentation was located in Resident #C's clinical record regarding notification of her physician or daughter [legal representative] regarding her increased agitation and need for total assistance with transfers. A "Nursing Progress Notes" dated 1/28/12 at 2:20 P.M., included, but was not limited to, "Resident [#C] observed on floor when C.N.A. walked into room... Skin tear present on right inner hand... swelling present... Daughter [legal representative] and physician notified of fall..." On 6/20/12 at 11:45 A.M., in an interview, the Director of Nursing [DoN] indicated Resident #C's physician was notified of her increased confusion on 1/23/12; however, her physician was not notified of her need for increased assistance with care or transfers until 1/28/12 after an unwitnessed fall.			

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R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure 1 of 1 residents was free from physical abuse from 1 C.N.A.; for 1 of 3 residents reviewed for allegations of physical abuse in a sample of 10 residents reviewed. [Resident #K; C.N.A. #5; Housekeeper #4] Findings include: A facility incident reported to ISDH on 5/28/12 was reviewed on 6/15/12. The incident involved Resident #K and C.N.A. #5. The report included, but was not limited to, the following information: "Date of Alleged: 5/27/12 Brief Description of Incident: Resident [Resident #K] was seated in the dining room after breakfast. C.N.A. [C.N.A. #5] was attempting to get resident up and back to her room. Housekeeper [Housekeeper #4] witnessed C.N.A. grabbing the resident's arm and teller her 'Wait until I get your a_ _ in the room.'	R0052	1. This allegation of abuse was investigated per facility protocol. It was the determination of the facility after investigation that physical abuse did not occur related to this incident. 2. Other residents' safety was maintained by the facility following the abuse prevention policy and procedure. 3. A review of the abuse prevention policy and procedures was completed. An abuse in-service was scheduled for all staff members to attend. This in-service will be offered at multiple convienient times to ensure all staff are able to attend on or before 7/20/12. 4. Reporting of all allegations of suspicious activity whether defined as abuse or not will be expected by all staff members. Any staff members failing to follow our abuse prevention policy and procedures will recieve disiplinary action. Any allegations of abuse will be immediatly reported to the appropriate agencies including the Indiana State Department of Health. Any allegations of abuse will be discussed during the quarterly Quality Assurance	07/20/2012

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	Per F/U [follow-up] 6/1/12: C.N.A. [#5] resigned during the course of the investigation. Type of Injury: None Immediate Action Taken: Resident assessed head to toe for signs of physical abuse. C.N.A. was suspended pending investigation." At the survey entrance conference on 6/18/12 at 10:00 A.M., the Director of Nursing was requested to provide all of the investigative documentation available that had been completed for this incident. On 6/20/12 at 7:30 A.M., the Administrator provided a folder containing written statements from C.N.A. #5, Housekeeper #4 and Q.M.A. #3. The statement from C.N.A. #5 was dated 5/30/12, and indicated "On [Saturday--with a line crossed through it], Sunday...." There was no information in the statement related to an incident on 5/27/12. A statement from Housekeeper #4 was dated 5/26/12 and indicated "On 5/26/12, I [Housekeeper's name] observed [C.N.A. #5's name] grab a patient out of the chair		committee meeting ongoing.	

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	in KSV [Keepsake Village--the secured/locked Alzheimer's unit] activity room, squeezing her arm stating 'Wait until I get your a _ _ in the room.' The patient was screaming and yelling 'STOP.' That's when I exited the room." A statement from Q.M.A. #3 was dated 5/27/12 at "approximately 1:30 P.M." The statement indicated "Said writer went on break with housekeeper name [Housekeeper #4's name]. [Housekeeper's name] looked at me and became nervous and said [Q.M.A. #3's name], I want to say something but I'm afraid. I said what's wrong, she then began to say, I don't think it's right for some of the aides to mistreat people. I said what do you mean. She said I don't know who to talk to and I went home last night and it is worry me because I seen it happened again today. I asked her what did you see. She said well that aide name [C.N.A. #5's name] pinched [Resident #K's name] yesterday and today and yesterday he told her wait till you get your a _ _ in the room. I can't do anything to you cause the camera is out here. With that I immediately told [Unit Manager's name]...." During the daily conference on 6/20/12 at 11:45 A.M., the Administrator was given the opportunity to submit any other			

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	investigative documentation related to this incident. In an interview at that time, he indicated the Housekeeper had attended the inservice on abuse and was aware of the reporting requirement, but during his interview with her, she had told him that she was afraid. The Administrator indicated he counseled the Housekeeper and stressed it was not her call to decide whether or not there was abuse, but her responsibility to report anything suspicious. On 6/21/12, the Administrator provided all of the documentation for the incident. An undated, one-page typed summary, identified by the Administrator as completed by him, included, but was not limited to, the following information: "I was notified on Sunday, May 27, 2012 about an incident that happened on Saturday, May 26, 2012... I immediately suspended [C.N.A. #5' name] pending investigation into the allegations... I met with [Housekeeper #4's name] on Monday, 5/28/11 at 11 A.M. [Housekeeper #4's name] repeated her story to me and told me that she did not know for sure what she saw was a problem until she went home and slept on it. She also needed to see how other staff members handled resident [Resident #K's name]. It was not until seeing others with			

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	resident [Resident K's name] on Sunday that she felt [C.N.A.#5's name] had mistreated her. I did counsel [Housekeeper #4's name] on the proper abuse reporting procedure. I also let her know that it is not her responsibility to judge guilty or not, but it is her responsibility to inform the administrator if she thinks something is inappropriately done to a resident. I met with [C.N.A. #5's name] on 5/30/12 at 11:15 A.M. [C.N.A. #5's name] was reluctant to come in and talk because he feared termination. I made it clear that refusing to talk to me made him appear guilty. He agreed to come in for the investigation. He provided a written statement. He said that he did not mistreat anyone and has never spoken inappropriately to a resident. He was sure that the housekeeper did not like him and had a personal grudge against him... I checked the camera footage to see if any suspicious activity was recorded. Nothing abnormal was noted on available security camera footage... The conclusion of the investigation leads to NO conclusive physical evidence that the incidents in this report were substantiated resident abuse. It is my opinion that an inappropriate comment			

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	made while residents were present did occur. [C.N.A. #5's name] did resign his position here before any formal reprimand could be made. He stated this untrue allegation as well as many other reasons for his resignation." Following the entrance conference on 6/18/12, the Director of Nursing provided the facility's Abuse Prevention Policy and Procedure, dated as revised on 9/7/11. The Policy outlined "Definitions of Abuse," "Indication of Abuse," "Worker Responsibilities," and "Documentation." The section for "Definitions of Abuse" included the following: "Physical Abuse--Any physical pain or injury which is willfully inflicted upon an elder by a person who has care or custody of, or who stands in position of trust with that elder, constitutes physical abuse. This includes, but is not limited to, direct beatings, sexual assault, unreasonable physical restraint, and prolonged deprivation of food or water... Psychological/Emotional Abuse--The willful infliction of mental suffering by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Examples of such abuse are: verbal assault, threats, instilling fear, humiliation, intimidation, isolation of an			

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	elder...." An addendum, titled "Hearth Management Abuse Prevention Addendum" listed an approval date of 9/27/11 with a review date of 4/11/12. The addendum included, but was not limited to, the following information: "Screening Protocol: All employees will have criminal background checks immediately upon hiring... Prevention of abuse training will be provided upon hiring and annual thereafter... Protection of Residents: In situations of suspected abuse involving resident to resident, visitor to resident or staff to resident, every effort to separate the persons involved without increasing the potential for additional danger will be implemented... Investigations: In situation of reported or suspected abuse/neglect, an investigation will be conducted by the Executive Director, Director of Nursing, Business Office Manager, designee. The investigation will include immediately placing any involved staff on administrative leave, interviewing all persons pertinent to the claim,			

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	maintaining documentation of interviews and working to resolve the calm as soon as possible. Any allegations will be reported to the company, as well as all applicable state and federal agencies. Reporting: Employees will report all situations that may be considered abuse or neglect to a resident from any and all sources... Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator...." Inservices on "Abuse Prevention," using the facility's Policy and Procedure, were conducted on 3/16/12 and 4/20/12. The "Inservice Sign-In Sheet" for the inservice on 3/16/12 had listed a signature for attendance by C.N.A. #5. The "Inservice Sign-In Sheet" for the inservice on 4/20/12 listed a signature for attendance for both C.N.A. #5 and Housekeeper #4. This State Residential tag relates to Complaint IN00109927.			

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R0053	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure 1 of 1 residents was free from verbal abuse from 1 C.N.A.; for 1 of 3 residents reviewed for allegations of verbal abuse in a sample of 10 residents reviewed. [Resident #K; C.N.A. #5; Housekeeper #4] Findings include: A facility incident reported to ISDH on 5/28/12 was reviewed on 6/15/12. The incident involved Resident #K and C.N.A. #5. The report included, but was not limited to, the following information: "Date of Alleged: 5/27/12 Brief Description of Incident: Resident [Resident #K] was seated in the dining room after breakfast. C.N.A. [C.N.A. #5] was attempting to get resident up and back to her room. Housekeeper [Housekeeper #4] witnessed C.N.A. grabbing the resident's arm and teller her 'Wait until I get your a_ _ in the room.' Per F/U [follow-up] 6/1/12: C.N.A. [#5] resigned during the course of the investigation.	R0053	1. This incident was investigated by the facility according to state guidelines and the facilities abuse prevention policy and procedure. The conclusion of that investigation was that there was no evidence to substantiate the verbal abuse allegation. 2. Other residents' safety was maintained by the facility following the abuse prevention policy and procedure. 3. A review of the abuse prevention policy and procedures was completed. An abuse in-service was scheduled for all staff members to attend. This in-service will be offered at multiple convienient times to ensure all staff are able to attend on or before 7/20/12. 4. Reporting of all allegations of suspicious activity whether defined as abuse or not will be expected by all staff members. Any staff members failing to follow our abuse prevention policy and procedures will recieve disiplinary action. Any allegations of abuse will be immediatly reported to the appropriate agencies including the Indiana State Department of Health. Any allegations of abuse will be discussed during the quarterly Quality Assurance committee meeting ongoing.	07/20/2012

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	Type of Injury: None Immediate Action Taken: Resident assessed head to toe for signs of physical abuse. C.N.A. was suspended pending investigation." At the survey entrance conference on 6/18/12 at 10:00 A.M., the Director of Nursing was requested to provide all of the investigative documentation available that had been completed for this incident. On 6/20/12 at 7:30 A.M., the Administrator provided a folder containing written statements from C.N.A. #5, Housekeeper #4 and Q.M.A. #3. The statement from C.N.A. #5 was dated 5/30/12, and indicated "On [Saturday--with a line crossed through it], Sunday...." There was no information in the statement related to an incident on 5/27/12. A statement from Housekeeper #4 was dated 5/26/12 and indicated "On 5/26/12, I [Housekeeper's name] observed [C.N.A. #5's name] grab a patient out of the chair in KSV [Keepsake Village--the secured/locked Alzheimer's unit] activity room, squeezing her arm stating 'Wait until I get your a _ _ in the room.' The			

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		A. BUILDING 00 B. WING	06/21/2012

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	patient was screaming and yelling 'STOP.' That's when I exited the room." A statement from Q.M.A. #3 was dated 5/27/12 at "approximately 1:30 P.M." The statement indicated "Said writer went on break with housekeeper name [Housekeeper #4's name]. [Housekeeper's name] looked at me and became nervous and said [Q.M.A. #3's name], I want to say something but I'm afraid. I said what's wrong, she then began to say, I don't think it's right for some of the aides to mistreat people. I said what do you mean. She said I don't know who to talk to and I went home last night and it is worry me because I seen it happened again today. I asked her what did you see. She said well that aide name [C.N.A. #5's name] pinched [Resident #K's name] yesterday and today and yesterday he told her wait till you get your a _ _ in the room. I can't do anything to you cause the camera is out here. With that I immediately told [Unit Manager's name]...." During the daily conference on 6/20/12 at 11:45 A.M., the Administrator was given the opportunity to submit any other investigative documentation related to this incident. In an interview at that time, he indicated the Housekeeper had attended the inservice on abuse and was			

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	aware of the reporting requirement, but during his interview with her, she had told him that she was afraid. The Administrator indicated he counseled the Housekeeper and stressed it was not her call to decide whether or not there was abuse, but her responsibility to report anything suspicious. On 6/21/12, the Administrator provided all of the documentation for the incident. An undated, one-page typed summary, identified by the Administrator as completed by him, included, but was not limited to, the following information: "I was notified on Sunday, May 27, 2012 about an incident that happened on Saturday, May 26, 2012... I immediately suspended [C.N.A. #5' name] pending investigation into the allegations... I met with [Housekeeper #4's name] on Monday, 5/28/11 at 11 A.M. [Housekeeper #4's name] repeated her story to me and told me that she did not know for sure what she saw was a problem until she went home and slept on it. She also needed to see how other staff members handled resident [Resident #K's name]. It was not until seeing others with resident [Resident K's name] on Sunday that she felt [C.N.A.#5's name] had mistreated her. I did counsel [Housekeeper #4's name] on the proper			

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	abuse reporting procedure. I also let her know that it is not her responsibility to judge guilty or not, but it is her responsibility to inform the administrator if she thinks something is inappropriately done to a resident. I met with [C.N.A. #5's name] on 5/30/12 at 11:15 A.M. [C.N.A. #5's name] was reluctant to come in and talk because he feared termination. I made it clear that refusing to talk to me made him appear guilty. He agreed to come in for the investigation. He provided a written statement. He said that he did not mistreat anyone and has never spoken inappropriately to a resident. He was sure that the housekeeper did not like him and had a personal grudge against him... I checked the camera footage to see if any suspicious activity was recorded. Nothing abnormal was noted on available security camera footage... The conclusion of the investigation leads to NO conclusive physical evidence that the incidents in this report were substantiated resident abuse. It is my opinion that an inappropriate comment made while residents were present did occur. [C.N.A. #5's name] did resign his position here before any formal reprimand could be made. He stated this untrue			

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	allegation as well as many other reasons for his resignation." Following the entrance conference on 6/18/12, the Director of Nursing provided the facility's Abuse Prevention Policy and Procedure, dated as revised on 9/7/11. The Policy outlined "Definitions of Abuse," "Indication of Abuse," "Worker Responsibilities," and "Documentation." The section for "Definitions of Abuse" included the following: "Physical Abuse--Any physical pain or injury which is willfully inflicted upon an elder by a person who has care or custody of, or who stands in position of trust with that elder, constitutes physical abuse. This includes, but is not limited to, direct beatings, sexual assault, unreasonable physical restraint, and prolonged deprivation of food or water... Psychological/Emotional Abuse--The willful infliction of mental suffering by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Examples of such abuse are: verbal assault, threats, instilling fear, humiliation, intimidation, isolation of an elder...." An addendum, titled "Hearth Management Abuse Prevention			

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	Addendum" listed an approval date of 9/27/11 with a review date of 4/11/12. The addendum included, but was not limited to, the following information: "Screening Protocol: All employees will have criminal background checks immediately upon hiring... Prevention of abuse training will be provided upon hiring and annual thereafter... Protection of Residents: In situations of suspected abuse involving resident to resident, visitor to resident or staff to resident, every effort to separate the persons involved without increasing the potential for additional danger will be implemented... Investigations: In situation of reported or suspected abuse/neglect, an investigation will be conducted by the Executive Director, Director of Nursing, Business Office Manager, designee. The investigation will include immediately placing any involved staff on administrative leave, interviewing all persons pertinent to the claim, maintaining documentation of interviews and working to resolve the calm as soon as possible. Any allegations will be reported to the company, as well as all			

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	applicable state and federal agencies. Reporting: Employees will report all situations that may be considered abuse or neglect to a resident from any and all sources... Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator...." Inservices on "Abuse Prevention," using the facility's Policy and Procedure, were conducted on 3/16/12 and 4/20/12. The "Inservice Sign-In Sheet" for the inservice on 3/16/12 had listed a signature for attendance by C.N.A. #5. The "Inservice Sign-In Sheet" for the inservice on 4/20/12 listed a signature for attendance for both C.N.A. #5 and Housekeeper #4. This State Residential tag relates to Complaint IN00109927.			

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R0117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure that a minimum of one awake staff person with both a current Cardiopulmonary Resuscitation (CPR) and First Aid certificate, was on site at all times, in that 71 of 72 staff members did not have a current CPR and First Aid certification. This deficient practice had the potential to affect 108 of 108 residents residing in the facility.	R0117	1. A training class for our nurses was held on 6/27/12 to meet the first aid requirement. 2. There is 1 awake person onsite with current CPR and First Aid certifications at all times. 3. Review of Policy and Procedures requirement for first aid certification. Business office manager will verify upon hire all employees with first aid certification to ensure accurate files are up to date. 4. The number of staff members	06/27/2012

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	Findings include: During daily conference on 6/19/12 at 2:45 P.M., the Director of Nursing was requested to provide documentation of all licenses, registrations, certifications, and in-services. On 6/20/12 at 8:00 A.M., the Vice President of Operations provided a binder which contained licenses, certifications, and CPR/First Aid certificates. Review of these documents at that time indicated only one staff member had current CPR and First Aid certificates. During a daily conference on 6/21/12, at 3:00 p.m., the Director of Nursing was given the opportunity to provide the C.P.R. and First Aid certifications for any other staff currently employed. In an interview at that time, she indicated the facility's employee training and in-services provided CPR only and not First Aid. The Executive Director indicated he did not know both were required.		currently CPR and First Aid certified will be part of our quarterly QA meeting from 6/27/12 ongoing. This will ensure proper staffing on each shift.	

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the proper functioning of the night door alarm and failed to establish a written program for maintenance of the night door alarm. The deficient practice impacted 1 of 1 facility night door alarm and had the potential to impact 81 of 108 residents residing in the non-locked unit of the facility. Findings include: On 6/20/12 at 5:20 A.M., the facility entrance was observed locked. The night door alarm was used from 5:20 A.M. to 5:44 A.M. No facility staff answered the door alarm and all doors to the facility were locked preventing entrance into the	R0148	1. On 6/21/12 the battery for the front door bell was changed. An operational check was completed to ensure proper function of the door and alerting system. An in-service was performed on 6/21/12 with the nursing staff to ensure proper knowledge of nighttime operation of the front door. (See Attachment C) 2. Weekly secure door operation checklist was expanded to include all secure doors function during different hours of operation. This checklist will be performed by our maintenance staff. 3. Review of policy and procedures to include secure door operation. The front door and alert system were added to the weekly secure door operation checklist. 4. Maintenance staff	06/21/2012

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	facility. On 6/20/12 at 5:44 A.M., the facility was notified by phone of need to enter the facility. At that time, Licensed Practical Nurse #4 unlocked the locked entrance door. On 6/20/12 at 5:48 A.M., in an interview, L.P.N. #4 indicated she knew nothing about the "night door alarm" and how it functioned. She indicated all residents of the facility had keys to the doors and could enter with their individual keys when the entrance door was locked for the night. L.P.N. #4 indicated when an ambulance was called after hours [when the doors are locked] she would have someone stand at the front door to let them [ambulance personnel] in the facility. On 6/20/12 at 7:30 A.M., in an interview, the Executive Director indicated that when the entrance door alarm was activated or pushed, the staff would be alerted through their pagers. At that time, the facility written program for the front door alarm system was requested. On 6/20/12 at 12:00 P.M., the Executive		will perform operational checks on the secure doors to verify proper operation during varying hours of operation. A review of the door operation audit will be done at the QA meeting ongoing.	

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	Director indicated the facility did not have a written program in place for the front door alarm and did not have any maintenance logs for checking the function of the alarm; however, the front door alarms would be added to all security checks.			

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain equipment in a clean, sanitary manner in 1 of 1 kitchen. These deficient practices had the potential to affect 108 of 108 residents who ate meals from the kitchen. Findings include: 1. During the initial observation of the kitchen on 6-18-12 at 10:15 a.m., a shelf was observed to contain two 8-quart clear plastic containers stacked together. The inside of the bottom container contained moisture. During an interview at this same time, the Director of Food Services indicated the items were clean. He indicated items are air-dried after washing. 2. A Chefmate food slicer was observed to contain food debris on the food contact surface. During an interview at this same time, the Director of Food Services indicated the	R0154	1. On 6/18/12 the containers were immediately separated for proper drying and storage. The food slicer was immediately cleaned as it is after every use. The skillet in question was discarded immediately. All dishes and utensils were checked for cleanliness. 2. Review of all kitchen equipment cleaning schedule was performed by our food service director. 3. Reviewed our kitchen sanitation policy and procedures. An equipment cleaning checklist was instituted to be performed and initialed by each shift. An in-service will be performed on 7/09/12 with our dietitian to ensure compliance. (See Attachment F) 4. The food service director will review kitchen equipment cleanliness as needed and report any discrepancies to the QA committee meeting quarterly and ongoing.	06/21/2012

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	slicer is usually cleaned after each use. 3. A shelf adjacent to the food preparation counter was observed to contain two stacks of large and small skillets. One small skillet contained greasy food residue and felt greasy to touch. During an interview at this same time, the Director of Food Services indicated this item should be discarded. He then discarded the item into a trash receptacle. "Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24" effective 11/13/04 indicates the following: "SEC 295. (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations...." and " SEC 304(a) After cleaning and sanitizing, equipment and utensils: (1) shall be air-dried or used after adequate draining as specified in 21 CFR 178.1010(a), before contact with food...."			

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to document the specific criteria used, a summary of information collected, and the decision-making process used to demonstrate that 4 of 4 residents reviewed, who resided on the Alzheimer's unit, were appropriately evaluated for admittance to the facility Dementia/Alzheimer's secured/locked unit; and failed to evaluate 1 of 1 resident who experienced a change in condition. This deficiency affected 4 residents in a sample of 10 residents reviewed. [Residents #B, #C, #D, and #K] Findings include: 1. The clinical record for Resident #K was reviewed on 6/21/12 at 9:00 A.M. The resident was admitted directly to the facility's secured/locked Alzheimer's unit on 5/13/12. She was admitted from another Residential-licensed facility that did not have a secured/locked Alzheimer's unit. Diagnoses included, but were not	R0214	1. Created an admission summary form (See Attachment D). This form ensures that all relevant information is gathered to appropriately place a resident in our secure memory care, Keepsake Village. 2. Review of all current Keepsake Village residents and completion of the admission summary form. This will be completed on or before 7/9/12. 3. This new form will be an evaluation tool for all new resident admissions to Keepsake Village. This form will be completed by the nursing staff and reviewed by the Executive Director prior to admission. 4. The nursing staff will complete this form prior to any new admissions for Keepsake Village. The Director of Nursing will complete a quarterly audit of this form and present it to the quarterly QA meeting ongoing.	07/09/2012

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		A. BUILDING 00 B. WING	06/21/2012

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HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

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	limited to, advanced dementia with aphasia [unable to speak], history of ulcerative colitis with chronic constipation, pelvic cystic lesion, coronary artery disease, lower extremity edema, and osteoarthritis. On 6/21/12 at 9:23 A.M., the resident was observed ambulating with staff in the dining room. When approached, the resident smiled and began speaking. Her communication was non-sensical with "word salad" responses to simple questions such as "How are you?" She remained calm and pleasant, and staff took her by the hand and directed her to an activity in the lounge area. An "Assessment and Care Plan for Indiana Assisted Living Facilities" form, identified as "Pre-Admission" and dated 4/9/12, included, but was not limited to, the following information: "No assistive device (for mobility)--Independent for ambulation; Toileting=patting on pants has to go to restroom. If dehydrated will become constipated; is resistive to showering--doesn't like; sometimes can use fork/spoon. Regular/sandwiches, finger foods are easier. Loves sweets; wanders during night/hourly checks; mumbles a lot. Sometimes able to communicate with			

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	staff. Frequent difficulty; responds to simple direct questions; Current and Past Behavioral Issues=Does like to carry a doll with her. Comforted by holding hand...." There was no information on the pre-admission assessment form indicating why the resident was appropriate for admission to the facility's secured/locked Alzheimer's unit. A "History and Physical" form, completed by the attending physician on 5/22/12, indicated "... appears to be transferring from another facility. Requiring a secured unit. There is little prior records for review. Patient has aphasia with advanced dementia. Unable to provide any history." There was no information from the physician related to how he determined that the resident required a secured unit. A subsequent summary of all information collected from available sources, and used to evaluate the need and appropriateness of this resident's admission to the secured/locked Alzheimer's unit, was not found. In an interview on 6/21/12 at 10:10 A.M., the Administrator indicated they did not			

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	have any evaluation documentation related to the reasons residents were admitted to the Alzheimer's unit. He indicated they had a physician's orders, and believed that was sufficient. 2. Tour of the locked [dementia] unit was initiated on 6/18/12 at 10:30 A.M. with L.P.N. #1. At that time, in an interview with L.P.N. #1, Resident #D was identified as non-interviewable, with a history of behaviors and recent admission to the geriatric psychiatric facility, independently mobile with her walker, and a history of falls. On 6/18/12 at 1:45 P.M., Resident #D's record was reviewed. diagnoses included, but were not limited to, dementia with behavioral disturbances and hypothyroidism. Resident #D was admitted to the facility's assisted living on 2/13/12 and transferred to the facility's locked [dementia] unit on 3/16/12. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 2/8/12, no time, included, but was not limited to,			

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	"Mobility: Independent with ambulation... Orientation/Memory/Cognitive Function: Judgment and memory are not always good. Needs monitoring and guidance and occasional redirection... Communication: Usually able [to communicate with staff and understand others]... Current and Past Behavioral Issues: Easily worried and anxious..." There were no other "Assessment and Care Plan for Indiana Assisted Living Facilities" located in Resident #D's clinical record. A "Nursing Progress Notes" dated 2/13/12, no time, included, but was not limited to, "Resident arrived [to assisted living]... alert to person and place... upset with family... very agitated..." Resident #D's nursing progress notes from 2/13/12 through 2/24/12 included notes regarding her agitation and refusal of care. A "Nursing Progress Notes" dated 2/24/12 at 5:30 P.M., included, but was not limited to, "Resident [#D] sent to [area hospital] for evaluation and treatment..." A "Nursing Progress Notes" dated 3/16/12 at 4:40 P.M., included, but was			

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	not limited to, "Resident returned from hospital..." A "Physician's Orders" dated 3/16/12, no time, included, but was not limited to, "Re-Admit to the Hearth at Tudor Gardens Secure [locked dementia] Unit..." No evaluation was located in Resident #D's clinical record regarding her admission or criteria for admission to the facility's locked unit. On 6/18/12 at 3:00 P.M., Resident #D's evaluation for admission to the locked unit was requested from the director of Nursing [DoN]. On 6/21/12 at 11:30 A.M., in an interview, the DoN indicated the facility did not have an individual evaluation for Resident #D's admission to the facility's locked unit. 3. During initial tour of the facility's locked dementia unit, in an interview, L.P.N. #1 identified Resident #B as non-interviewable with a recent change in condition regarding ambulation and history of falls with injury. On 6/18/12 at 12:55 P.M., Resident #B's record was reviewed. diagnoses included,			

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	but were not limited to, dementia and cellulitis of the left leg. Resident #B was admitted to the facility directly to the locked dementia unit on 9/30/11. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 9/29/11, no time, included, but was not limited to, "Mobility: Ambulates independently, transfers independently... Social Service: Orientation/Memory/Cognitive Function: Judgment and memory are not always good. Needs monitoring and guidance and occasional redirection... Current and past behavioral issues: Emotional states do not create an unusual demand on others..." A "Nurse's Notes" dated 9/30/11 at 5:15 P.M., included, but was not limited to, "New resident admit..." No documentation was located in Resident #B's clinical record regarding evaluation for admission to the facility's locked dementia unit. On 6/18/12 at 3:00 P.M., Resident #B's evaluation for the locked unit was requested from the director of Nursing [DoN].			

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	On 6/21/12 at 11:30 A.M., in an interview, the DoN indicated the facility did not have an individual evaluation completed by the facility for Resident #B's admission to the locked unit. 4. During initial tour of the facility's locked dementia unit, L.P.N. #1 identified Resident #C as non-interviewable requiring assistance with activities of daily living and a history of falls without injury. On 6/20/12 at 6:05 A.M., Resident #C's record was reviewed. diagnoses included, but were not limited to, hypertension, vascular dementia, and cerebral vascular accident with left sided hemiplegia. Resident #C was admitted to the facility's assisted living on 1/16/12 and then transferred to the facility's locked dementia unit on 2/15/12. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 12/21/11, no time, included, but was not limited to, "Fall Risk: Services Provided: Uses wheelchair primary mode of transportation able to ambulate with walker... Independent with ambulation... Requires escort to most daily meals,			

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	activities and outings... High [fall risk]... Transferring: [Resident #C] Independent with transfers... Requires occasional assistance and or cueing [with transfers]..." A "Nursing Progress Notes" dated 2/15/12 at 2:00 P.M., included, but was not limited to, "Resident [#C] transferred to KSV [Keepsake Secure Village], the facility's locked dementia unit..." There was no documentation of an evaluation or "Assessment and Care Plan for Indiana Assisted Living Facilities" for the transfer on 2/15/12 to the locked dementia unit. On 6/20/12 at 11:30 A.M., the evaluation and updated service plan or assessment for Resident #C's transfer to the locked dementia unit was requested from the DoN. On 6/21/12 at 11:30 A.M., in an interview, the DoN indicated the facility did not have an individual evaluation completed by the facility for Resident #C's admission to the locked unit. 5. On 6/18/12 at 3:00 P.M., the facility admission policy for the assisted living and Keepsake Secured Village [KSV] [locked dementia unit] was received from			

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	the Executive director. The "Residency Requirements for Keepsake Village" dated 6/12, included, but was not limited to, "Policy Statement: The prospective resident or residents: must have a diagnosis of dementia, Alzheimer's or other cognitive impairment... An intake interview prior to admission will be performed to determine KSV eligibility to include, but not limited to, physician's history and physical, interview with family and resident, a nursing assessment to included decreased judgment, behaviors, wandering tendencies, medication regime and mini-mental exam..." This State Residential tag refers to Complaint IN00109927.			

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to identify and document the services provided for fall prevention, to 2 of 9 residents identified with current and history of falls [Residents #B and #E]; and failed to ensure the resident or the resident's legal representative signed the agreed upon Service Plan for 2 of 10	R0217	1. A chart audit was performed to ensure proper signatures on the most current service plans. Correct signatures will be attained by 7/9/12. 2. A chart audit was performed to ensure proper signatures on the most current service plans. Correct signatures will be attained by 7/9/12. 3. Reviewed policy and	07/09/2012

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	residents [Residents #D and #B] reviewed for Service Plan signatures; in a sample of 10 residents reviewed. Findings include: 1. On 6/18/12 at 12:55 P.M., Resident #B's record was reviewed. Diagnoses included, but were not limited to, dementia and cellulitis of the left leg. Resident #B was admitted to the facility directly to the locked dementia unit on 9/30/11. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 9/29/11, no time, included, but was not limited to, "Mobility: Ambulates independently, transfers independently... Social Service: Orientation/Memory/Cognitive Function: Judgment and memory are not always good. Needs monitoring and guidance and occasional redirection... Current and past behavioral issues: Emotional states do not create an unusual demand on others..." A "Quarterly Assessment and Care Plan For Indiana Assisted Living Facilities" dated 3/9/12, no time, included, but was not limited to, "Mobility: Resident ambulates independently... Transferring:		procedures with admissions staff to ensure service plans will be properly signed before admission. Reviewed with director of nursing the policy and procedure for quarterly and significant changes of condition updates to be properly signed on the resident service plan. 4. The director of nursing will monitor all service plans to ensure proper signatures are present and timely. This will be reviewed during the quarterly QA meeting ongoing.	

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	Resident independent with transfers..." No other "Assessment and Care Plan for Indiana Assisted Living Facilities" after 3/9/12 were located in Resident #B's clinical record. A "Nursing Progress Notes" dated 5/5/12 at 8:00 A.M., included, but was not limited to, "Resident observed on floor in TV room sitting on buttocks... Action taken: Resident alert to self able to move on unit freely... Outcome: Family and M.D. notified..." A "Nursing Progress Notes" dated 5/16/12 at 9:30 A.M., included, but was not limited to, "Resident observed on floor... tripped over residents wheelchair... Action taken: M.D. notified, open area noted on left eye... Outcome: Family/M.D. notified..." A "Nursing Progress Notes" dated 5/16/12 at 1:00 P.M., included, but was not limited to, "Resident noted tripping over objects... Action taken: M.D. made aware of resident and sent to emergency room..." A "Nursing Progress Notes" dated 5/18/12 at 4:40 P.M., included, but was not limited to, "Resident's wife request resident to be sent to the emergency room			

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	related to fall on 5/16/12 states resident with complaints of dizziness and head pain... Resident was sent to emergency room on 5/16/12 and sent back with diagnosis of contusion..." A "Nursing Progress Notes" dated 5/22/12, no time, included but was not limited to, "Resident returned from hospital... noted with difficulty transferring and ambulating..." A "Nursing Progress Notes" dated 6/11/12 at 7:00 P.M., included, but was not limited to, "Fall without injury..." On 6/18/12 at 3:00 P.M., documentation of the fall prevention services provided to Resident #B was requested from the DoN. On 6/19/12 at 9:00 A.M., the DoN provided a "Quarterly Assessment and Care Plan For Indiana Assisted Living Facilities" dated 6/15/12. The assessment included, but was not limited to, "Mobility: Resident currently using wheelchair for ambulation due to resident has had a decline in ambulating... Transferring: Resident requires assistance with transfers..." On 6/19/12 at 2:45 P.M., the DoN indicated the facility did not have any			

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	documentation of services offered for falls prior to 6/15/12. Resident #B was admitted to the facility directly to the locked dementia unit on 9/30/11. A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 9/29/11, no time, did not have a signature for "Resident/Responsible Party." On 6/19/12 at 9:00 A.M., in an interview, the DoN indicated the facility did not have other documentation with a signature on it for the "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities." 2. During initial tour of the locked dementia unit, in an interview with L.P.N. #1, Resident #D was identified as non-interviewable, with a history of behaviors and recent admission to the geriatric psychiatric facility, independently mobile with her walker, and a history of falls. On 6/18/12 at 1:45 P.M., Resident #D's record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbances and hypothyroidism.			

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	A "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities" dated 2/8/12, no time, did not include a signature for "Resident/Responsible Party." On 6/19/12 at 9:00 A.M., in an interview, the DoN indicated the facility did not have other documentation with a signature on it for the "Pre-Admission Assessment and Care Plan for Indiana Assisted Living Facilities." 3. The clinical record for Resident #E was reviewed on 6/18/12 at 1:30 P.M. Diagnoses included, but were not limited to, degenerative joint disease, hyperlipidemia [high cholesterol disease], senile dementia--Alzheimer's type, and multi-nodular goiter. On 6/5/12, she was admitted to an acute care hospital following a fall in the facility. Diagnoses at that time included right parietal subdural hematoma, left inferior orbital [eye socket] "blow out" fracture with bleeding into the maxillary sinus, a left eyelid laceration, and left knee abrasion. A "Home Discharge Instructions" form from a certified nursing home, dated May, 2011, indicated the resident was a fall risk, required bed and chair alarms, and			

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HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had received therapies. A "Nursing Progress Notes" entry, dated 5/31/12 at 10:00 A.M. The note indicated "Post fall--Resident ambulating in main dining room and fell. C.N.A. stated that they were attempting to get to resident to assist with ambulation. Staff re-educated on assisting resident to ambulate. Resident currently on antibiotic for urinary tract infection, sinus infection." Subsequent notes were dated: 6/4/12 at 10:00 A.M., "Post fall--Resident observed on floor in apartment after investigation of fall; and 6/6/12 at 10:00 A.M.--"Post fall--Resident was admitted to hospital related to fall 6/5/12." A 90-day "Assessment and Care Plan For Indiana Assisted Living Facilities" form, dated 2/24/12, had an entry addressing "Mobility," and indicated the following: "Fall Risk: Services Provided: Resident currently receiving restorative services. Requires assistance with ambulation. Resident kept in public area when awake due to resident will ambulate unassisted. Resident has history of falls. Resident ambulated by staff when resident attempting to ambulate independently. Resident uses wheelchair at times. Requires escort to most daily meals,			

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	activities and outings." A subsequent 90-day "Assessment and Care Plan," dated 5/13/12, listed the same information that was on the 2/24/12 plan. Other services to be provided to this resident with a history of falls and unassisted ambulation, or an updated Service Plan following the falls in May and June with new services, were not found. During the daily conference on 6/20/12 at 11:50 A.M., the Director of Nursing was given the opportunity to submit any additional evidence/documentation of specific services the facility was providing, or planned on providing, to this resident who had a history and 2 current falls--1 of which resulted in significant injuries. In an interview at that time, the Vice President of Operations, who had been the interim Administrator during the last annual survey, indicated she thought this issue had been cleared up from the previous year's findings of the same problem. At the final exit on 6/21/12 at 3:00 P.M., no additional documentation of a service plan addressing the resident's falls was			

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	provided for review. This State Residential tag relates to Complaint IN00109927.			

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to label food to indicate the date it was made or a use-by date, the facility failed to ensure a flour scoop was not stored inside the flour bin, and the facility failed to ensure employees practiced proper glove use and hand washing in the kitchen. These deficient practices had the potential to affect 108 of 108 residents who ate meals from the kitchen. Findings include: 1. During the initial observation of the kitchen on 6-18-12 at 10:15 a.m., a tray in the reach-in refrigerator was observed to contain 7 sealed fruit cups and two pitchers containing a dark liquid. One pitcher was full; the other was ¾ full. Another full pitcher was observed to contain a yellow liquid. These items did not contain labels. Also observed in the refrigerator was an 8-quart clear plastic container with a lid that contained 4 quarts of pineapple. This item contained a label with the date, " 6-8-12. " Also	R0273	1. The items in question were discarded or corrected immediately on 6/18/12. Kitchen staff members were in-serviced on proper sanitation and safe food handling standards. 2. A cleaning checklist is being utilized with staff signatures to ensure proper food sanitation is being completed. 3. A safe food handling standards in-service will be conducted on 7/09/12 reiterating the training for hand washing and glove usage in the kitchen. (See Attachment F) 4. The food service director will monitor the kitchen cleaning checklist. It will be reviewed at the quarterly QA meeting ongoing.	06/21/2012

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	observed in the refrigerator was a 20-ounce plastic bottle containing green tea. The seal was broken, and the bottle was less than full. During an interview at this same time, the Director of Food Services indicated the pitchers contained juice and lemonade, and that the 20-oz green tea belonged to a staff member. 2. On the counter next to the food preparation table and under the toaster were observed a clear plastic bag containing a loaf of Texas toast, a clear plastic bag containing two pieces of rye bread, a clear plastic bag containing a loaf of wheat bread, a clear plastic bag containing one-quarter loaf of wheat bread, a clear plastic bag containing one-half loaf of white bread, and a clear plastic bag containing four dinner rolls. These items did not contain labels and were not marked with a use-by date. During an interview at this same time, the Director of Food Services indicated he utilizes a first-in, first-out method of rotating food items. 3. In the walk-in freezer was observed an 8-quart plastic container containing a white, curd-like food item. This item did			

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	not contain a label. During an interview at this same time, the Director of Food Services indicated the item was gorgonzola cheese. 4. In the dry storage area were observed a stack of trays containing clear plastic bags of bread items. The top tray contained Texas toast; one full loaf and one half-loaf. The second tray contained unopened loaves of raisin bread. The third tray contained three unopened loaves of rye bread. The fourth tray contained four unopened packages of dinner rolls. These items did not contain labels and were not marked with a use-by date. During an interview at this same time, the Director of Food Services indicated he would speak with the bread delivery person regarding labeling of these items in the future. 5. Also in the dry storage area, a container labeled " flour " was observed to be open, and a scoop was inside the container. 6. On a shelf in the dry storage area were observed a 6-quart plastic container containing 4 quarts of rice, a 6-quart plastic container containing two quarts of			

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	crisped rice cereal, and a 6-quart plastic container containing five quarts of bran flakes cereal. Another shelf contained a 12-ounce package of strawberry glaze that had been opened and wrapped in plastic wrap. These items did not contain labels. 7. At 11:30 a.m., Dietary Staff #6 was observed with gloved hands to move from the food preparation area to the dry storage area. He was observed to retrieve a loaf of bread and return to the food preparation area, and then to open the bread bag and remove slices of bread. He was then observed to dish food into containers using a ladle. At no time during this observation did Dietary Staff #6 remove his gloves or wash his hands. During an interview at 12:52 p.m., the Director of Food Services indicated he had spoken with a representative from the bread company who had indicated he could provide color-coded twist ties to help keep track of food expiration dates by week. During the daily conference at 2:54 p.m., on 6-18-12, copies of the facility's food labeling, glove use, and hand washing policies were requested. On 6-19-12, at 9:15 a.m., the Executive			

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	Director provided copies of documents titled, " Food Safety, " " Storage of Food in Refrigeration, " and " Glove Use for Dietary Employees, " all with an approval date of 9-27-2011. The " Food Safety " policy was reviewed at that time, and included, but was not limited to, the following information: " All staff will be aware of proper food handling and storage procedures. " " All staff will be aware of proper handling of dirty and clean utensils. " " Food will be served in such a way as to prevent growth of bacteria. " " All food service staff will wash their hands upon entering the kitchen and when moving from one food prep area to another. " The document titled, " Storage of Food in Refrigeration " was reviewed at 9:17 a.m. This document included, but was not limited to, the following information: " Food being returned to storage after cooking or preparation must be covered. " " All containers must be labeled with the contents and date food item was placed in storage. " " Previously cooked foods can be held in refrigeration of 41 degrees F or lower for up to 3 days and then must be discarded. " " ...employee food items			

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	may not be stored in any refrigerator or freezer in the main kitchen. " The document titled, " Glove Use for Dietary Employees " was reviewed at 9:19 a.m. This document included, but was not limited to, the following information: " Gloves must be worn by any employee handling food in the kitchen. " " Gloves need to be changes [sic] as soon as they become soiled, before beginning a new task, at least every 4 hours during continual use, and after handling raw meat and before handling cooked or ready-to-eat foods .... " "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11-13-04 indicates the following: " SEC 129. (a) Food employees shall clean their hands ... (7) during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks .... " " SEC 171. (a) Food employees shall wash their hands as specified under section 128 of this rule ...food employees shall not contact exposed, ready-to-eat			

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	food with hands that have not been washed as specified in sections 129 and 130 of this rule and shall use suitable utensils, such as the following: (1) Deli tissue. (2) Spatulas. (3) Tongs. (4) Single-use gloves.... " "SEC 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1)...." " SEC 192. (a) A food specified in section 191(a) or 191(b) of this rule shall be discarded if it: (1) exceeds either of the temperature and time combinations specified in section 191(a) of this rule, except time that the product is frozen; (2) is in a container or package that does not bear a date or day; or (3) is appropriately marked with a date or day that exceeds a temperature and time combination as specified in section 191(a) of this rule. "			

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R0298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, record review, and interview, the facility failed to ensure the consultant Pharmacist monitored the EDK [Emergency Drug Kit] monthly and failed to ensure the EDK was not expired. The deficient practice affected 2 of 2 insulin EDK's of the facility and had the potential to affect 1 of 27 residents on the locked dementia unit and 4 of 81 residents on the non-locked unit. Findings include: On 6/18/12 at 10:30 A.M., tour of the locked dementia unit was initiated with L.P.N. #1. At that time, L.P.N. #1 identified 1 resident as an insulin dependent diabetic.	R0298	1. Immediately all expired medications in the EDK were destroyed or replaced with current medications. Our pharmacy consultant will ensure compliance of the EDK expiration dates on a monthly basis ongoing. 2. All EDK items were checked for currency. 3. Pharmacy consultant and director of nursing will be checking the EDK monthly to ensure no expired medication is on premises. 4. Pharmacy consultant and director of nursing will be checking the EDK monthly to ensure no expired medication is on premises.	07/09/2012

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	On 6/18/12 at 1:00 P.M., the Director of Nurses provided a list of residents in the facility who required special needs. Four residents in the non-locked part of the facility were identified as insulin-dependent diabetics, requiring the use of insulin. On 6/20/12 at 9:00 A.M., environmental tour was initiated with the Executive Director, the Environmental Services Director, and the Housekeeping Supervisor. On 6/20/12 at 9:45 A.M., 1 insulin EDK, located in the locked dementia unit refrigerator, had an expiration date of 5/2012. The EDK included the following insulin's: Novolog, Novolin 70/30, Novolin R, Novolin N, and Humalog 75/25. On 6/20/12 at 9:55 A.M., 1 insulin EDK, located in the assisted living medication refrigerator, had an expiration date of 7/2011. The EDK included the following insulin's: Novolog, Novolin 70/30, Novolin R, Novolin N, Humalog Mix 75/25, and Lantus. On 6/20 12 at 10:30 A.M., the Executive Director provided a policy and procedure, "Facility and Pharmacy EDK Monitoring/Expiration dated 9/27/11.			

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	The policy and procedure included, but was not limited to, "Procedure: The consultant Pharmacist will monitor the EDK monthly and will ensure compliance on expiration dates..." On 6/20/12 at 12:00 P.M., the Executive Director and DoN indicated the last visit of the consultant Pharmacist was on 5/2/12. They indicated the consultant Pharmacist visits monthly and alternates between units. They were unsure of what unit the consultant Pharmacist reviewed last.			

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R0301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to ensure proper labeling of medications located in the medication refrigerator. The deficient practice impacted 2 of 2 facility medication refrigerators and had the potential to affect 1 of 27 and residents residing on the locked dementia unit, and 81 of 81 residents living in the assisted living part of the facility. Findings include: On 6/18/12 at 10:30 A.M., tour of the locked dementia unit was initiated with L.P.N. #1. At that time, 1 resident was identified as a insulin dependent diabetic. On 6/20/12 at 9:00 A.M., environmental tour was initiated with the Executive	R0301	1. On 6/20/12 the lantus insulin pen and the bottle of apisol was labeled correctly.2. All medications were reviewed for proper labels and dates. This review was completed on or before 7/9/12.3. During monthly review by our pharmacy, dates and labels will be checked for compliance. All nurses will monitor their assigned carts by shift for date and label appropriateness. 4. The director of nursing will review random samples of medications monthly to ensure compliance of proper dates and labels. This will be reviewed at the quarterly QA meeting ongoing.	06/21/2012

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	Director, the Environmental Services Director, and the Housekeeping Supervisor. On 6/20/12 at 9:40 A.M., a new Lantus Insulin Pen with located in the locked dementia unit medication refrigerator without a resident label. The Lantus Insulin Pen had not been used. On 6/20/12 at 9:50 A.M., an open bottle of Apisol Injection [Tubersol], was located in the assisted living medication refrigerator without an open or use by date. On 6/20/12 at 10:00 A.M., in an interview, the DoN indicated she was aware of the need for labeling all medications with resident information and open dates.			

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R0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review, observation, and interview, the facility failed to ensure the proper disposal of an expired medication in 1 of 2 facility refrigerators and failed to ensure the return of medications no longer ordered for a resident in 1 of 1 resident reviewed for medication errors in a sample of 10 residents reviewed. [Resident #D] Findings include: 1. On 6/20/12 at 9:00 A.M., environmental tour was initiated with the Executive Director, the Environmental Services Director, and the Housekeeping Supervisor.	R0306	1. All expired or D/C medications were destroyed immediately on 6/20/12. 2. Reviewed destroyed medication logs to ensure timely response to discontinued or expired medication. 3. Review of policy and procedures for destruction of medications. 4. Director of nursing will monitor changes and expiration dates of medications and destroy them timely. This will be reviewed in the quarterly QA meeting ongoing.	07/09/2012

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HEARTH AT TUDOR GARDENS LLC	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/20/12 at 9:55 A.M., an open bottle of "Mary's Mouthwash" with an expiration date of 4/7/12 was located in the assisted living refrigerator. 2. On 6/18/12 at 10:30 A.M., during initial tour of the locked dementia unit, in an interview with L.P.N. #1, Resident #D was identified as non-interviewable, with a history of behaviors and recent admission to the geriatric psychiatric facility, independently mobile with her walker, and a history of falls. On 6/18/12 at 1:45 P.M., Resident #D's record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbances and hypothyroidism. A "Nursing Progress Notes"dated 5/21/12 at 4:00 P.M., included, but was not limited to, "Resident given Xanax 0.5 milligrams... no order for medication... M.D. notified of medication given without order... family aware..." On 6/21/12 at 11:30 A.M., the DoN indicated Resident #D had a previous order for Xanax prior to her re-admission to the facility on 3/16/12. She indicated the previous Xanax was left in the medication cart. The DoN indicated it was policy to destroy medication not			

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	re-ordered. On 6/21/12 at 3:45 P.M., the DoN provided a 'Controlled Drug Use Record" for Resident #D and the Xanax. The record included, but was not limited to, "6 pills destroyed on 6/19/12" with 2 signatures to witness disposal.			

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a weekly blood pressure measurement was recorded in the clinical record, for 1 of 1 resident who had a physician's order for a weekly blood pressure measurement; in a sample of 10 residents reviewed. [Resident #E] Findings include; The clinical record for Resident #E was reviewed on 6/18/12 at 1:30 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with agitation, lower extremity edema, multi-nodule goiter, and hyperlipidemia [high cholesterol disease]. The June, 2012 physician order recap [recapitulation] sheet listed an order, not dated, for "Monitor blood pressure weekly--call if systolic blood pressure less than 110 or any symptoms."	R0349	1. Physician was called to clarify the order for BP monitoring. Nursing staff will follow Physician orders obtained. 2. Random audit of clinical records for 11 out of 108 residents by the director of nursing ensuring that Physician orders are being followed. 3. Nursing staff in-serviced on following Physician orders on 7/9/12. 4. Review of clinical records randomly on a monthly basis by the director of nursing. Review of those findings in the quarterly QA meeting ongoing.	07/09/2012

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	The March, 2012 Treatment Record listed the order, but no blood pressure measurements were documented on the form. The April, 2012 Treatment Record also listed the order, but no blood pressure measurements were documented on the form. The May, 2012 Treatment Record listed the order, and blood pressures were documented on 5/2, 5/9, 5/16, 5/23, and 5/30/12. A "Vital Sign Flow Sheet" had monthly blood pressures documented on 2/3/12, 3/2/12, 4/1/12, 5/1/12, and 6/1/12. During the daily conference on 6/19/12 at 2:34 P.M., the Director of Nursing was given the opportunity to submit any additional evidence/documentation that the weekly blood pressure measurement had been taken and recorded. In an interview on 6/21/12 at 11:45 A.M., the Director of Nursing indicated she was unable to find any other documentation related to the weekly blood pressure measurements; did not know if the measurements were actually done; and, if done, why the measurements were not recorded.			

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R0352	410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on interview and record review, the facility failed to maintain nursing progress notes for a 5 month period between December 30, 2011 and May 31,2012; for 1 of 1 resident who had a history of chronic aggressive behaviors, and was a fall risk who had experienced at least recent 2 falls, in a sample of 10 residents reviewed. [Resident #E] Findings include: The clinical record for Resident #E was reviewed on 6/18/12 at 1:30 P.M. Diagnoses included, but were not limited to, degenerative joint disease, hyperlipidemia [high cholesterol disease], senile dementia--Alzheimer's type, and multi-nodular goiter. On 6/5/12, she was admitted to an acute care hospital following a fall in the facility. Diagnoses at that time included right parietal subdural hematoma, left inferior orbital [eye socket] "blow out" fracture with bleeding into the maxillary sinus, a left eyelid laceration, and left knee abrasion.	R0352	1. N/A2. Random audit of clinical records for 11 out of 108 residents by the director of nursing ensuring that proper nurse charting is in place. 3. Nursing staff in-serviced on policy and procedure for proper resident documentation on 7/9/12. 4. Review of clinical records randomly on a monthly basis by the director of nursing. Review of those findings in the quarterly QA meeting ongoing.	07/09/2012

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	A "Home Discharge Instructions" form from a certified nursing home, dated May, 2011, indicated the resident was a fall risk, required bed and chair alarms, and had received therapies. Incidents reported to ISDH indicated the resident had displayed behaviors of striking and pulling hair of 3 other residents on 8/17/12, 9/10/11, and 9/24/11. A physician's progress note, dated 12/20/11, indicated "Asked to see patient with staff's reports of increased behaviors. She is quite confused, slapping and spitting... Often approach helps, but not lately...." One "Nursing Progress Notes" entry found in the clinical record was dated 12/30/11. The next progress note found was dated 5/31/12 at 10:00 A.M. The note indicated "Post fall--Resident ambulating in main dining room and fell. C.N.A. stated that they were attempting to get to resident to assist with ambulation. Staff re-educated on assisting resident to ambulate. Resident currently on antibiotic for urinary tract infection, sinus infection." Subsequent notes were dated: 6/4/12 at 10:00 A.M., "Post fall--Resident observed on floor in apartment after investigation of fall; and 6/6/12 at 10:00 A.M.--"Post fall--Resident was admitted to hospital			

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	related to fall 6/5/12." During the daily conference on 6/19/12 at 2:34 P.M., the Director of Nursing was given the opportunity to submit any additional evidence/documentation of progress notes from nursing staff for the period between 12/30/11 and 5/31/12. In an interview on 6/21/12 at 11:45 A.M., the Director of Nursing indicated she could not find any nursing progress note documentation for this period.			